FORM 117A

The Commonwealth of Massachusetts
Department of Industrial Accidents
600 Washington Street – 7th Floor, Boston, Massachusetts 02111
Info. Line 800-323-3249 ext. 470 in Mass. Outside Mass. - 617-727-4900 ext. 470
http://www.mass.gov/dia

DIA Board # (If Known):

Please Print or Type

AGREEMENT FOR REDEEMING LIABILITY BY LUMP SUM UNDER G.L. CH. 152, SEC. 48 FOR INJURIES OCCURRING BEFORE NOV. 1, 1986

Board Number _____ Employee _____

Insurer Or Self-insurer _____ Employer _____

Insurer's Address _____

LUMP SUM AMOUNT $_____

Total Deductions $_____ Net to Claimant $_____

Total Payments $_____ Insurer's Claim Number _____

Received of _____ the Lump Sum of _____

_____ dollars and _____ cents ($_____) making with weekly payments already received by me , the total sum of _____ dollars and _____ cents ($_____).

Said payments are received in redemption of the liability for all weekly payments now or in the future due me under the Workers' Compensation Act, for all injuries received by_____

on or about _____ while in the employ of _____

subject to the approval of the Department of Industrial Accidents.

_____ _____
Claimant's Signature — Witness's Signature

_____ _____
Claimant's Address — Witness's Address

_____ _____

_____ _____
Signature of Insurer's Rep. — Date of Agreement

STRIKE OUT IF NOT APPLICABLE

I understand that from the LUMP SUM amount stated above, the amounts listed below will be deducted and paid to the following parties:

1. $_____	Attorney's Fee	_____ Name	_____ Address
2. $_____	Liens	_____	_____
3. $_____		_____	_____
4. $_____		_____	_____
5. $_____		_____	_____
6. $_____		_____	_____
7. $_____		_____	_____

STRIKE OUT IF NOT APPLICABLE

I understand that, in addition to the LUMP SUM amount stated above, the insurer or self-insurer will pay all outstanding reasonable medical bills incurred as of this date: _____

I understand that after all of the above deductions, including attorneys fees and other liens, I will receive the net amount of $_____. I further understand that this is a complete and final settlement of my claim and that I will not be able to reopen my claim or seek further benefits because of this injury. I am fully satisfied with this settlement.

_____ _____
Claimant's Signature and Date — Witness's Signature and Date

(over)

Employee: Age: _____ Average Weekly Wage: _____ Dependents: _____ Comp. Rate: _____

Social Security No.*: _____ On Social Security Disability: Yes ___ No ___

Occupation: _____ If yes, from what date?: _____

Injury: Nature: _____

Place and Date of all injuries included _____

_____

Cause:_____

Liability: Accepted: Yes____ No ____ If No, state reason _____

_____

_____

If accepted, what is pending issue:_____

_____

_____

Medical: Original Diagnosis: _____

_____

Present Medical Condition: _____

Present Work Capacity: _____

_____

PERTINENT MEDICAL REPORTS AND BILLS SHOULD BE ATTACHED HERETO

COMPENSATION PAID: §34 $_____ §35A $_____ §34A $_____

§35 $_____ §36 $_____ §31 $_____

PLEASE GIVE A BRIEF HISTORY OF THE CASE AND INDICATE WHY THE SETTLEMENT IS IN THE EMPLOYEE'S BEST INTEREST (Specify any requested allocation of claimant's net amount):

Signatures:

_____ _____

Counsel for Insurer Counsel for Employee

*Disclosure of Social Security Number is Voluntary. It will aid in the processing of this document.